IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
ABINGDON DIVISION

WILLIAM E. BOYD,	)	
Plaintiff	)	
	)	
v.	)	Civil Action No. 1:04cv00078
	)	**MEMORANDUM OPINION**
JO ANNE B. BARNHART,	)	
Commissioner of Social Security,	)	By: PAMELA MEADE SARGENT
Defendant	)	United States Magistrate Judge

In this social security case, I vacate the final decision of the Commissioner denying benefits and remand the case to the ALJ for further consideration.

I. Background and Standard of Review

Plaintiff, William E. Boyd, filed this action challenging the final decision of the Commissioner of Social Security, ("Commissioner"), denying plaintiff's claim for disability insurance benefits, ("DIB"), under the Social Security Act, as amended, ("Act"), 42 U.S.C.A. § 423 (West 2003). Jurisdiction of this court is pursuant to 42 U.S.C. § 405(g). This case is before the undersigned magistrate judge upon transfer pursuant to the consent of the parties under 28 U.S.C. § 636(c)(1).

The court's review in this case is limited to determining if the factual findings of the Commissioner are supported by substantial evidence and were reached through application of the correct legal standards. *See Coffman v. Bowen*, 829 F.2d 514, 517 (4th Cir. 1987). Substantial evidence has been defined as "evidence which a reasoning

mind would accept as sufficient to support a particular conclusion. It consists of more than a mere scintilla of evidence, but may be somewhat less than a preponderance." *Laws v. Celebrezze*, 368 F.2d 640, 642 (4th Cir. 1966). '"If there is evidence to justify a refusal to direct a verdict were the case before a jury, then there is "substantial evidence."'" *Hays v. Sullivan*, 907 F.2d 1453, 1456 (4th Cir. 1990) (quoting *Laws*, 368 F.2d at 642).

The record shows that Boyd protectively filed his application for DIB on or about November 14, 2002, alleging disability as of November 13, 2002, based on pain, difficulty breathing and depression. (Record, ("R."), at 64, 65-68, 78, 105.) The claim was denied initially and upon reconsideration. (R. at 35-37, 43, 44-46.) Boyd then requested a hearing before an administrative law judge, ("ALJ"). (R. at 47.) The ALJ held a hearing on February 12, 2004, at which Boyd was represented by counsel. (R. at 214-65.)

By decision dated April 30, 2004, the ALJ denied Boyd's claim for benefits. (R. at 21-32.) The ALJ found that Boyd met the disability insured status requirements of the Act through the date of the decision. (R. at 31.) The ALJ found that Boyd had not engaged in substantial gainful activity since November 13, 2002. (R. at 31.) The ALJ also found that the medical evidence established that Boyd had severe impairments, namely degenerative disc disease, borderline intellectual functioning and chronic obstructive pulmonary disease, ("COPD"),[1] but he found that Boyd did not have an impairment or combination of impairments listed at or medically equal to one

[1]COPD refers to any disorder, e.g. asthma, chronic bronchitis and pulmonary emphysema, marked by persistent obstruction of bronchial air flow. *See* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, ("Dorland's"), 483 (27th ed. 1988).

listed at 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 31.) The ALJ further found that Boyd's allegations regarding his limitations were not totally credible. (R. at 31.) The ALJ found that Boyd had the residual functional capacity to perform simple, unskilled light[2] work. (R. at 29, 31.) Thus, the ALJ found that Boyd could not perform his past relevant work. (R. at 31.) Based on Boyd's age, education, work experience and residual functional capacity and the testimony of a vocational expert, the ALJ found that other jobs existed in the national economy that Boyd could perform, including those of a small parts assembler, a production inspector/grader and a hand packer. (R. at 30, 32.) Therefore, the ALJ found that Boyd was not disabled at any time through the date of his decision and was not eligible for DIB benefits. (R. at 32.) *See* 20 C.F.R. § 404.1520(g) (2004).

After the ALJ issued his decision, Boyd pursued his administrative appeals, (R. at 8-17), but the Appeals Council denied his request for review. (R. at 5-7.) Boyd then filed this action seeking review of the ALJ's unfavorable decision, which now stands as the Commissioner's final decision. *See* 20 C.F.R. § 404.981 (2004). The case is before this court on Boyd's motion for summary judgment filed December 6, 2004, and the Commissioner's motion for summary judgment filed January 26, 2005.

II. Facts

Boyd was born in 1954, (R. at 65, 220), which, at the time of the ALJ's decision, classified him as a "person closely approaching advanced age" under 20

[2]Light work involves lifting items weighing up to 20 pounds at a time with frequent lifting or carrying of items weighing up to 10 pounds. If someone can perform light work, he also can perform sedentary work. *See* 20 C.F.R. § 404.1567(b) (2004).

C.F.R. § 404.1563(d) (2004). Boyd has a high school education and past work experience as a coal miner. (R. at 219, 220-21.)

Boyd testified at his hearing that he could write "okay," but he stated that he was not "the best reader." (R. at 219.) However, he stated that he took and passed a written test to obtain his driver's license. (R. at 219.) Boyd testified that he worked approximately 28 years in the coal mines. (R. at 220-21.) He stated that the last coal mining job he had was in low coal, requiring him to work on his knees all day. (R. at 221.) Boyd testified that he stopped working in November 2002, when the coal company he worked for was bought by another company and his doctor told him he could not pass a physical for another employer. (R. at 221-22.) He stated that if the company had not sold out, he would have tried to continue working despite his doctor's advice to the contrary. (R. at 222-23.)

Boyd testified that he was diagnosed with black lung disease in 1995, after which time the Mine Safety and Health Administration, ("MSHA"), recommended that he move to a less dusty area of the mine, but which Boyd did not do. (R. at 224-25.) He stated that his breathing had improved since he stopped working. (R. at 231.) Boyd also testified that he suffered from lower back pain, which had worsened over the years and which sometimes radiated into his leg and caused numbness. (R. at 226, 230.) However, he stated that he did not use a walker, cane or crutches. (R. at 228.) Boyd testified that although Dr. Sutherland had opined that he would require back surgery, he had not been referred to a neurologist or orthopedist because he lacked insurance. (R. at 228-29.)

Boyd testified that walking for more than 10 minutes caused leg numbness. (R. at 226-27.) He further testified that his black lung disease made it difficult for him to walk. (R. at 232.) He stated that sitting caused back pain, requiring him to lie down two or three times per day for 30 minutes to an hour each time. (R. at 229.) Boyd further stated that he had difficulty sleeping and that Dr. Sutherland had prescribed sleeping pills. (R. at 230-31.) He testified that he sometimes awakened during the night due to pain and difficulty breathing. (R. at 231.)

Boyd further testified to having difficulty with his right knee for the previous three to four months, stating that squatting or sitting caused it to "lock[] up." (R. at 233.) He testified that Dr. Sutherland opined that his knee required surgery, but again, Boyd stated that he was not referred to a specialist because he lacked insurance. (R. at 234.)

Boyd, who is right-handed, testified that he had been diagnosed with right carpal tunnel syndrome, which had resulted in decreased strength. (R. at 235-36.) He stated that he continued to work in the mines after being diagnosed with carpal tunnel syndrome. (R. at 236.) Again, Boyd testified that surgery was recommended, but he did not follow this advice. (R. at 237.) He further testified that he had difficulty with his left arm and hand, stating that he experienced numbness of the ring finger of the left hand. (R. at 237.) Nonetheless, Boyd stated that he continued to work for years after this problem began. (R. at 238.)

Finally, Boyd testified that Dr. Sutherland referred him to psychologist B. Wayne Lanthorn for an evaluation. (R. at 239.) He stated that he had difficulty

focusing, concentrating and dealing with stress. (R. at 241.) He stated that he might get out and walk around his yard on a pretty day, but he noted that he had no energy. (R. at 242.) Boyd testified that he would get up and wash, eat breakfast, watch some television and lie down. (R. at 242.) He stated that he did not help out much around the house, but noted that he sometimes mowed his yard, which was less than a quarter of an acre, and which took 10 to 15 minutes. (R. at 243, 245.) He also stated that he fed his dog. (R. at 246.) Boyd testified that he used to enjoy raccoon hunting, but was no longer able to climb the mountain. (R. at 246.) He stated that it had been at least a year since he had been raccoon hunting. (R. at 246.) However, he stated that he had a current hunting license just in case he felt like going hunting. (R. at 247.) Boyd stated that he enjoyed sitting in the vehicle and listening to the dogs as they chased the raccoons. (R. at 247.) However, he stated that he did not carry a gun with him because he no longer actually hunted. (R. at 248.) Boyd stated that he and his wife dined out occasionally. (R. at 249.) He stated that he had a current driver's license and would sometimes go to the grocery store for his wife, a distance of approximately six miles. (R. at 249-50.) Boyd testified that he was able to count well enough to know whether he was given the correct change. (R. at 251-52.) He stated that relatives occasionally visited him and his wife. (R. at 253.)

Robert Jackson, a vocational expert, also was present and testified at Boyd's hearing. (R. at 257-64.) He classified Boyd's work in the coal mines as medium[3] and semi-skilled, but he stated that the skills were not transferable to lesser exertional

[3]Medium work involves lifting items weighing up to 50 pounds at a time with occasional lifting and carrying of items weighing up to 25 pounds. If someone can do medium work, he also can do light and sedentary work. *See* 20 C.F.R. § 404.1567(c) (2004).

levels. (R. at 258-59.) Jackson was asked to consider a hypothetical individual of Boyd's age, education and past work experience, who could perform light work, who could occasionally climb, balance, stoop, kneel, crouch and crawl, who should avoid concentrated exposure to extreme cold, heat, wetness, humidity, vibration and hazards and who should avoid all exposure to fumes, odors, gases and poor ventilation. (R. at 259.) Jackson testified that such an individual could perform the jobs of a small parts assembler, a production inspector/grader and a hand packer, all at the light level of exertion. (R. at 260.) Jackson further testified that such an individual could perform the sedentary[4] jobs of an assembler, a production inspector/grader/sorter and a cashier. (R. at 260-61.) Jackson was next asked to consider the same individual, but who had a poor or no ability to follow work rules, to deal with the public, to use judgment, to interact with supervisors, to deal with work stresses, to maintain attention and concentration, to understand, remember and carry out complex and detailed job instructions, to relate predictably in social situations and to demonstrate reliability and who had a fair ability to relate to co-workers, to function independently, to understand, remember and carry out simple job instructions and to behave in an emotionally stable manner. (R. at 261.) Jackson testified that such an individual could perform no jobs. (R. at 262.) Next, Jackson testified that an individual who was limited as set forth in Dr. Sutherland's physical and mental assessments would not be able to perform any work. (R. at 262-63.) He likewise testified that an individual who had to lie down up to three times during the day for 30 minutes to an hour each time would not be able to perform any work. (R. at 263.)

[4]Sedentary work involves lifting items weighing up to 10 pounds at a time and occasionally lifting or carrying items like docket files, ledgers and small tools. *See* 20 C.F.R. § 404.1567(a) (2004).

In rendering his decision, the ALJ reviewed records from Buchanan County Public Schools; Dr. Gregory Wagner, M.D.; Dr. German Iosif, M.D.; B. Wayne Lanthorn, Ph.D., a licensed clinical psychologist; Dr. J.P. Sutherland, D.O.; R.J. Milan Jr., Ph.D., a state agency psychologist; Dr. Richard M. Surrusco, M.D., a state agency physician; and University of Virginia Sciences Center Department of Physical Medicine and Rehabilitation.

The record shows that Dr. Gregory Wagner, M.D., Director of the Division of Respiratory Disease Studies with the Department of Health and Human Services, wrote a letter on February 29, 1996, stating that chest x-rays of Boyd taken on October 31, 1995, revealed category 1, simple coal workers' pneumoconiosis.[5] (R. at 136.)

Boyd saw Dr. J.P. Sutherland, M.D., from 1993 to 2004. (R. at 189-202.) From February 1993 to September 1996, Boyd complained of back pain and numbness of the left hand. (R. at 201-02.) A physical examination in December 1995 revealed a decreased range of motion of the lumbar spine and positive straight leg raising at 35 degrees. (R. at 201.) A neurological examination was within normal limits. (R. at 201.) X-rays showed advanced degenerative joint disease of the lumbar spine with osteophytes associated with the L3, L4 and L5 levels of the spine. (R. at 201.) Boyd was diagnosed with left sciatica and degenerative joint disease of the lumbar spine. (R. at 201.) He was treated conservatively with medications. (R. at 201.) In September 1996, Boyd again exhibited a decreased range of motion of the lumbar spine with paravertebral muscle spasm. (R. at 201.) He again had positive straight leg raising at

[5]Simple coal workers' pneumoconiosis is a condition caused by large amounts of coal dust in the lungs and typically characterized by centrilobular emphysema. *See* Dorland's at 1318.

35 degrees. (R. at 201.) Despite having a ganglion cyst of the left hand, Boyd exhibited no neurological deficits. (R. at 201.) An x-ray of the left hand showed no evidence of fracture, dislocation or acute bony abnormalities. (R. at 201.) He was diagnosed with degenerative joint disease of the lumbar spine, left sciatica, a ganglion cyst of the fourth finger of the left hand and right carpal tunnel syndrome. (R. at 201.) He again was treated conservatively with medications. (R. at 201.) By December 1996, Boyd continued to exhibit a decreased range of motion of the lumbar spine and positive bilateral straight leg raising at 35 degrees. (R. at 200.) However, his neurological examination remained within normal limits. (R. at 200.) Boyd was diagnosed with degenerative osteoarthritis of the lumbar spine and bilateral sciatica. (R. at 200.) He was treated conservatively with medications, heat therapy and Dynawave therapy of the lumbar spine. (R. at 200.)

On September 25, 1996, Boyd saw Dr. Frank McCue III, M.D., at the University of Virginia Health Sciences Center Department of Physical Medicine and Rehabilitation, at Dr. Sutherland's referral. (R. at 211-13.) A physical examination revealed full-grade weakness of the grasp of the left hand compared to the right, and Boyd's sensation was decreased to light touch in the ulnar distribution of the left hand. (R. at 211.) Boyd exhibited a positive Tinel's sign[6] on the left greater than the right. (R. at 211.) Dr. McCue also performed nerve conduction studies, revealing evidence of a left ulnar mononeuropathy at the wrist consistent with ulnar nerve compression. (R. at 211.) However, he noted no evidence of axonal loss. (R. at 211.) Dr. McCue

[6]Tinel's sign is a tingling sensation in the distal end of a limb when percussion is made over the site of a divided nerve. It indicates a partial lesion or the beginning regeneration of the nerve. *See* Dorland's at 1526.

further noted evidence of a borderline left median neuropathy at the level of the wrist. (R. at 211.) Dr. McCue noted no evidence of an ulnar neuropathy at the elbow. (R. at 211.)

Boyd again saw Dr. Sutherland from May 1997 through May 2003. (R. at 192-200.) Over this time period, Boyd complained of weakness, dizziness, "smothering," back pain, chest pain with deep breathing, bilateral hand pain, muscle spasms, chronic lung disease and leg pain. (R. at 192-200.) An electrocardiogram, ("EKG"), performed in May 1997 revealed a sinus bradycardia,[7] unifocal premature ventricular contractions, no acute ST elevations or depression and no acute Q waves. (R. at 200.) Boyd was diagnosed with chronic fatigue syndrome, anterior chest wall syndrome, Barlow syndrome,[8] vertigo, a functional heart murmur and viral gastroenteritis with weight loss. (R. at 200.) He was prescribed Lomotil and Buspar. (R. at 200.) From August 10, 1998, through May 12, 2003, physical examinations consistently revealed a decreased range of motion of the lumbar spine, (R. at 192-97, 199), occasionally associated with paravertebral muscle spasms, (R. at 192, 194, 196-98), and positive straight leg raising at 35 degrees. (R. at 192-93, 195-98.) He was diagnosed with dysfunctional low back syndrome, degenerative joint disease of the lumbar spine, bilateral sciatica, costochondritis, lumbar myositis,[9] chronic pain syndrome and stress anxiety disorder. (R. at 192-200.) Boyd was treated

---

[7]Bradycardia refers to a slowness of the heart rate, as evidenced by slowing of the pulse rate to less than 60. *See* Dorland's at 230.

[8]Barlow syndrome is another term for mitral valve prolapse. *See* Dorland's at 1630.

[9]Lumbar myositis refers to inflammation of a voluntary muscle. *See* Dorland's at 1092.

conservatively with various medications, including Decadron, Singulair, a Proventil inhaler, Lodine, Naprosyn, Cortisone, Celebrex, Baclofen, Daypro, Darvocet, Advair, Accolate, Uniphyl, Ultram, Skelaxin and Klonopin, as well as heat packs and Dynawave therapy. (R. at 192-200.)

On December 12, 2000, Boyd complained of bilateral hand pain. (R. at 198.) A physical examination revealed synotenovitis[10] of both hands with carpal tunnel syndrome of the right wrist associated with a decreased range in supination and pronation. (R. at 197.) Boyd also exhibited weakness of the third, fourth and fifth fingers of the right hand. (R. at 197.) Dr. Sutherland opined that Boyd had neuralgia of the median and radial nerves, but there was no evidence of neurological deficits. (R. at 197.) X-rays of the right wrist revealed mild degenerative osteoarthritis. (R. at 197.) Boyd was diagnosed with right carpal tunnel syndrome and tenosynovitis of the right hand. (R. at 197.) He was treated conservatively. (R. at 197.) On November 13, 2002, Dr. Sutherland noted that Boyd was "unable to do gainful employment ... patient has a clinical presentation of permanent and total disability." (R. at 195.) In February 2003, a chest x-ray showed interstitial markings and severe interstitial pulmonary fibrosis consistent with emphysema. (R. at 194.) In March 2003, physical examination revealed fine rhonchi with inspiratory stridor and expiratory wheeze with intercostal retractions. (R. at 193.) He was diagnosed with acute bronchitis with

[10]It appears that Dr. Sutherland meant tenosynovitis, which is the inflammation of a tendon and its enveloping sheath. *See* STEDMAN'S MEDICAL DICTIONARY, ("Stedman's), 823 (1995). Further references to this diagnosis will be to tenosynovitis.

COPD, bronchiectasis[11] and emphysema. (R. at 193-95.)

Boyd saw Dr. German Iosif, M.D., on June 10, 2003, for evaluation of his shortness of breath. (R. at 137-47.) Boyd denied the regular presence of cough, wheezing, sputum production or any history of pleuritic pain or coughing up blood. (R. at 137.) Dr. Iosif noted no evidence that Boyd had ever been hospitalized for any sort of respiratory problems. (R. at 137.) A physical examination revealed that Boyd was alert and fully oriented with no evidence of respiratory or other distress. (R. at 138.) Dr. Iosif noted that Boyd had normal mood, concentration, short- and long-term memories and attention span. (R. at 138.) No cervical vascular abnormalities, tracheal deviation, lymphadenopathy, thyroid enlargement or nodules were noted. (R. at 139.) There was normal configuration of the thorax, percussion was normal with symmetrical resonance, he had excellent breath sounds throughout both lungs on pulmonary auscultation, regular cardiac rhythm, normal tones and no murmurs, clicks or gallops. (R. at 139.) Boyd's extremities were without edema, joint deformities and vascular abnormalities. (R. at 139.) Inspection, palpation and range of motion examination of the spine were unremarkable. (R. at 139.) Spirometries were obtained and all flows and volumes were normal. (R. at 139.) Dr. Iosif concluded that Boyd's complaints of exertional dyspnea could not be correlated with any objective, physical or spirometric pulmonary abnormalities. (R. at 139.) He opined that Boyd might have silicosis[12] or coal workers' pneumoconiosis. (R. at 139.) However, Dr. Iosif noted

[11]Bronchiectasis refers to chronic dilation of the bronchi marked by fetid breath and paroxysmal coughing with the expectoration of mucopurulent matter. *See* Dorland's at 236.

[12]Silicosis is pneumoconiosis due to the inhalation of the dust of stone, sand or flint containing silicon dioxide, with formation of generalized nodular fibrotic changes in both lungs. *See* Dorland's at

that Boyd did not have any indication of respiratory functional impairment. (R. at 139.) Dr. Iosif advised that good quality chest x-rays be taken and reviewed by a qualified physician. (R. at 139.) He further concluded that Boyd's complaints of chronic low back pain were not supported by the objective physical findings. (R. at 139.) However, he noted that he was unable to comment regarding Boyd's musculoskeletal functional impairments without radiographic correlation. (R. at 139.)

On July 22, 2003, Dr. Richard M. Surrusco, M.D., a state agency physician, completed a physical residual functional capacity assessment, finding that Boyd could perform medium work. (R. at 180-87.) He found Boyd's subjective allegations only partially credible. (R. at 182.) Dr. Surrusco found that Boyd could occasionally climb, balance, stoop, kneel, crouch and crawl. (R. at 183.) He further found that Boyd had no manipulative, visual or communicative limitations. (R. at 183-84.) Dr. Surrusco found that Boyd should avoid concentrated exposure to extreme temperatures, wetness, humidity, noise, vibration and work hazards such as machinery and heights. (R. at 185.) He found that Boyd should avoid all exposure to fumes, odors, dusts, gases and poor ventilation. (R. at 185.) Dr. Michael J. Hartman, M.D., another state agency physician, affirmed Dr. Surrusco's findings on September 9, 2003. (R. at 187.)

On July 25, 2003, R.J. Milan Jr., Ph.D., a state agency psychologist, completed a Psychiatric Review Technique form, ("PRTF"), finding that Boyd suffered from a nonsevere anxiety-related disorder. (R. at 165-79.) Milan concluded that Boyd was

---

1527.

not restricted in his activities of daily living, experienced no difficulties in maintaining social functioning, had no difficulties in maintaining concentration, persistence or pace and experienced no episodes of decompensation. (R. at 175.) Howard Leizer, Ph.D., another state agency psychologist, affirmed Milan's findings on September 9, 2003. (R. at 165.)

Boyd continued to see Dr. Sutherland through January 2004. During this time period, he complained of back pain, leg pain and right knee pain. (R. at 189-91.) Physical examinations consistently revealed a decreased range of motion of the lumbar spine in lifting, bending, stooping and squatting, positive bilateral straight leg raising at 35 degrees and vertebral muscle spasm. (R. at 189-91.) On August 13, 2003, Dr. Sutherland noted neuralgia radiating from both sciatic notches into the lateral margin of the foot. (R. at 191.) Dr. Sutherland noted that Boyd was alert and fully oriented, but had chronic pain syndrome. (R. at 191.) Over this time period, Boyd was diagnosed with chronic bronchitis/emphysema, tenosynovitis of the right knee, degenerative lumbar disc disease, chronic pain syndrome, COPD, bilateral sciatica, depression/anxiety and bilateral neuralgia in the legs. (R. at 189-91.) On January 14, 2004, Boyd complained of right knee pain. (R. at 189.) He had a decreased range of motion of the right knee in flexion and extension with laxity of the anterior cruciate ligament of the right knee. (R. at 189.) Boyd was diagnosed with tenosynovitis of the right knee and internal derangement of the right knee. (R. at 189.) He was treated with Motrin and Flexeril. (R. at 189.)

On September 3, 2003, Boyd saw B. Wayne Lanthorn, Ph.D., a licensed clinical psychologist, for a psychological evaluation. (R. at 158-64.) Lanthorn noted that

Boyd was alert and fully oriented, exhibited no signs of psychotic processes, displayed no evidence of delusional thinking and denied having hallucinations. (R. at 159.) However, Lanthorn reported that Boyd showed signs of depression including a blunt, flat affect, as well as a monotone speech pattern. (R. at 159.) He made erratic eye contact and had overall poor self-esteem. (R. at 159.) Boyd reported that he had a high school education, but repeated the sixth grade. (R. at 160.) He stated that he was diagnosed with "rock dust in [his] lungs" in 1995, but encouraged his physician not to report it and continued to work for seven years thereafter. (R. at 160-61.) Boyd further reported ongoing "nerve problems," noting that he was easily aggravated and irritable and was difficult to be around. (R. at 161.) He noted that he avoided social contacts, would snap at his wife, was constantly tired and enervated and awakened fatigued. (R. at 161.) He stated that he had little energy to initiate or persist at tasks. (R. at 161.) Boyd reported preferring to be alone, and he stated that he was unable to remember things. (R. at 161.) Lanthorn noted that Boyd was quite anxious, which Boyd described as follows: "[s]ometimes, I just start shaking and I feel weak." (R. at 161.)

Lanthorn administered the Wechsler Adult Intelligence Scale-Third Edition, ("WAIS-III"), test, on which Boyd obtained a verbal IQ score of 69, a performance IQ score of 68 and a full-scale IQ score of 66, placing him in the extremely low range of current intellectual functioning. (R. at 162.) Lanthorn also administered the Pain Patient Profile, ("P/3"), which revealed that Boyd was in the most severe range on the somatization, depression and anxiety scales. (R. at 162-63.) Lanthorn diagnosed Boyd with major depressive disorder, single episode, severe, pain disorder associated with both psychological factors and a general medical condition, generalized anxiety

disorder, mild mental retardation and a Global Assessment of Functioning, ("GAF"), score of 40-45.[13] (R. at 163-64.) Nonetheless, Lanthorn opined that Boyd was competent to manage his own funds. (R. at 164.) Lanthorn stated that Boyd had moderately severe limitations in his overall adaptability skills when all psychological factors were considered. (R. at 164.) He advised that Boyd consider seeking mental health therapy and a psychiatric evaluation of his ongoing medication regimen. (R. at 164.) Lanthorn further opined that Boyd might need to be referred to a pain management center in the future. (R. at 164.)

Lanthorn also completed a Medical Assessment Of Ability To Do Work-Related Activities (Mental). (R. at 155-57.) He concluded that Boyd had a fair ability to relate to co-workers, to function independently, to understand, remember and carry out simple job instructions and to behave in an emotionally stable manner and a good ability to maintain personal appearance. (R. at 155-56.) In all other areas of adjustment, Lanthorn concluded that Boyd had a poor or no ability. (R. at 155-56.)

On January 15, 2004, Dr. Sutherland completed a Medical Assessment Of Ability To Do Work-Related Activities (Physical). (R. at 203-05.) He concluded that Boyd could lift items weighing up to 20 pounds occasionally and up to five pounds

---

[13]The GAF scale ranges from zero to 100 and "[c]onsider[s] psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness." DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FOURTH EDITION, ("DSM-IV"), 32 (American Psychiatric Association 1994).. A GAF score of 31 to 40 indicates that the individual has "[s]ome impairment in reality testing or communication ... OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood ...." DSM-IV at 32. A GAF score of 41 to 50 indicates "[s]erious symptoms ... OR any serious impairment in social, occupational, or school functioning ...." DSM-IV at 32.

frequently. (R. at 203.) He further found that Boyd could stand and/or walk for a total of one hour each, but for only 10 minutes or approximately less than 100 feet each without interruption. (R. at 203.) Dr. Sutherland also found that Boyd could sit for a total of two hours, but for only 30 minutes without interruption. (R. at 204.) He concluded that Boyd could never climb, stoop, kneel, crouch or crawl, but could occasionally balance. (R. at 204.) Dr. Sutherland found that Boyd's abilities to reach, to handle and to push and/or pull were affected by his impairments. (R. at 204.) He concluded that Boyd should avoid heights, moving machinery, temperature extremes, chemicals, dust, noise, fumes, humidity and vibration. (R. at 205.)

Dr. Sutherland also completed a Medical Assessment Of Ability To Do Work-Related Activities (Mental) the same day. (R. at 206-08.) He found that Boyd had a fair ability to understand, remember and carry out simple job instructions, to maintain personal appearance and to behave in an emotionally stable manner. (R. at 206-07.) In all other areas of adjustment, Dr. Sutherland opined that Boyd had a poor or no ability. (R. at 206-07.) Nonetheless, Dr. Sutherland again found Boyd capable of managing his own funds. (R. at 208.)

In a letter to Boyd's counsel dated January 15, 2004, Dr. Sutherland stated that he had treated Boyd since 1993 for recurrent medical problems, including advanced degenerative osteoarthritis of the cervical and lumbar spines, tenosynovitis with internal derangement of the right knee, chronic bronchitis/emphysema and history of COPD, chronic pain syndrome and stress anxiety disorder. (R. at 209.) He reported that various medicines and modalities had been tried over the years, but that he had been unable to relieve Boyd's physical or emotional dysfunction. (R. at 209.) Dr.

Sutherland opined that Boyd was unable to do any gainful employment, as he would be unable to pass any physical evaluation for even a sedentary occupation. (R. at 209.) He stated that Boyd's "prognosis is extremely poor for ever returning to any type of gainful employment." (R. at 209.)

On February 3, 2004, Lanthorn completed a form faxed to him from Boyd's counsel, indicating that Boyd met or equaled 20 C.F.R. Part 404, Subpart P, Appendix 1, § 12.05(C), the listing for mental retardation, and that Boyd's mental retardation was in existence prior to age 22. (R. at 210.)

III. Analysis

The Commissioner uses a five-step process in evaluating DIB claims. *See* 20 C.F.R. § 404.1520 (2004); *see also Heckler v. Campbell*, 461 U.S. 458, 460-62 (1983); *Hall v. Harris*, 658 F.2d 260, 264-65 (4th Cir. 1981). This process requires the Commissioner to consider, in order, whether a claimant 1) is working; 2) has a severe impairment; 3) has an impairment that meets or equals the requirements of a listed impairment; 4) can return to his past relevant work; and 5) if not, whether he can perform other work. *See* 20 C.F.R. § 404.1520 (2004). If the Commissioner finds conclusively that a claimant is or is not disabled at any point in this process, review does not proceed to the next step. *See* 20 C.F.R. § 404.1520(a) (2004).

Under this analysis, a claimant has the initial burden of showing that he is unable to return to his past relevant work because of his impairments. Once the claimant establishes a prima facie case of disability, the burden shifts to the Commissioner. To

satisfy this burden, the Commissioner must then establish that the claimant has the residual functional capacity, considering the claimant's age, education, work experience and impairments, to perform alternative jobs that exist in the national economy. *See* 42 U.S.C.A. § 423(d)(2) (West 2003); *McLain v. Schweiker*, 715 F.2d 866, 868-69 (4th Cir. 1983); *Hall*, 658 F.2d at 264-65; *Wilson v. Califano*, 617 F.2d 1050, 1053 (4th Cir. 1980).

By decision dated April 30, 2004, the ALJ denied Boyd's claim for benefits. (R. at 21-32.) The ALJ found that Boyd met the disability insured status requirements of the Act through the date of the decision. (R. at 31.) The ALJ found that Boyd had not engaged in substantial gainful activity since November 13, 2002. (R. at 31.) The ALJ also found that the medical evidence established that Boyd had severe impairments, namely degenerative disc disease, borderline intellectual functioning and COPD, but he found that Boyd did not have an impairment or combination of impairments listed at or medically equal to one listed at 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 31.) The ALJ further found that Boyd's allegations regarding his limitations were not totally credible. (R. at 31.) The ALJ found that Boyd had the residual functional capacity to perform simple, unskilled light work. (R. at 29, 31.) Thus, the ALJ found that Boyd could not perform his past relevant work. (R. at 31.) Based on Boyd's age, education, work experience and residual functional capacity and the testimony of a vocational expert, the ALJ found that other jobs existed in the national economy that Boyd could perform, including those of a small parts assembler, a production inspector/grader and a hand packer. (R. at 30, 32.) Therefore, the ALJ found that Boyd was not disabled at any time through the date of his decision and was not eligible for benefits. (R. at 32.) *See* 20 C.F.R. § 404.1520(g) (2004).

As stated above, the court's function in the case is limited to determining whether substantial evidence exists in the record to support the ALJ's findings. The court must not weigh the evidence, as this court lacks authority to substitute its judgment for that of the Commissioner, provided her decision is supported by substantial evidence. *See Hays*, 907 F.2d at 1456. In determining whether substantial evidence supports the Commissioner's decision, the court also must consider whether the ALJ analyzed all of the relevant evidence and whether the ALJ sufficiently explained her findings and her rationale in crediting evidence. *See Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 439-40 (4th Cir. 1997).

Boyd first argues that the ALJ erred in his credibility determination. (Plaintiff's Motion For Summary Judgment And Memorandum Of Law, ("Plaintiff's Brief"), at 8-11.) Boyd next argues that the ALJ erred by failing to find that he met the listing for mental retardation, found at 20 C.F.R. Part 404, Subpart P, Appendix 1, § 12.05(C). (Plaintiff's Brief at 11-18.) Boyd further argues that the ALJ erred in his weighing of the medical evidence by failing to grant controlling weight to the opinion of Dr. Sutherland, his treating physician. (Plaintiff's Brief at 18-23.) Finally, Boyd argues that the ALJ erred by posing an incomplete hypothetical to the vocational expert. (Plaintiff's Brief at 24-25.)

It is the province of the ALJ to assess the credibility of a witness or a claimant. *See Hays*, 907 F.2d at 1456; *Taylor v. Weinberger*, 528 F.2d 1153, 1156 (4th Cir. 1975). Ordinarily, the ALJ will not disturb the ALJ's credibility findings unless "it appears that [his] credibility determinations are based on improper or irrational

criteria." *See Breeden v. Weinberger*, 493 F.2d 1002, 1010 (4th Cir. 1974). The ALJ must determine through examination of the objective medical evidence whether the claimant has proven an underlying impairment that could reasonably be expected to produce the symptoms alleged, in the amount and degree alleged by the claimant. *See Craig v. Chater*, 76 F.3d 585, 594-96 (4th Cir. 1996). If the existence of such an impairment is established, the ALJ then must evaluate the intensity and persistence of the symptoms and the extent to which they affect the claimant's ability to work. *See Craig*, 76 F.3d at 594-95. Although a claimant's allegations about pain may not be discredited solely because they are not substantiated by objective evidence of the pain itself or its severity, they need not be accepted to the extent they are inconsistent with the available evidence. *See Craig*, 76 F.3d at 595.

Furthermore, an ALJ's assessment of a claimant's credibility regarding the severity of pain and symptoms is entitled to great weight when it is supported by the record. *See Shively v. Heckler*, 739 F.2d 987, 989-90 (4th Cir. 1984). As is the case of other factual questions, credibility determinations as to a claimant's testimony regarding pain are for the ALJ to make. *See Shively*, 739 F.2d at 989-90. To hold that an ALJ may not consider the relationship between the objective evidence and the claimant's subjective testimony would unreasonably restrict the ALJ's ability to meaningfully assess a claimant's testimony.

In his decision, the ALJ noted that Boyd suffered from impairments that could reasonably be expected to produce some degree of pain or discomfort, but further found that the evidence failed to establish that his pain was so severe as to prevent the

performance of all work activity. (R. at 28.) I find that substantial evidence supports this finding. As the ALJ noted, Boyd's activities of daily living contradict his subjective allegations of pain and limitations to the degree alleged. The record reveals that Boyd is able to drive a car, grocery shop for his wife, attend to his personal care, watch television, mow his small yard, walk around his yard, feed his dog and receive visits from relatives and friends. (R. at 242-53.) Although Boyd kept a current hunting license, he stated that he had not been hunting in more than a year at the time of the hearing. (R. at 246-47.) Boyd did testify that he still enjoyed sometimes riding with others to go hunting, but that he stayed in the vehicle, enjoying listening to the dogs tree the raccoons. (R. at 247.) I note that while Boyd's argument that the ALJ placed too much weight on the finding that Boyd maintained his hunting license might have some merit, I, nonetheless, find that there is other substantial evidence of record to support his finding. Aside from Boyd's daily activities, the record reveals that he had no difficulty walking and was never prescribed any assistive devices such as a cane or a walker. Likewise, he was never given wrist splints to treat his carpal tunnel syndrome. Moreover, Boyd admitted that he continued to work for several years after being told to stop working by his physician and he disregarded advice from MSHA to move to a less dusty area of the mine. Although Boyd testified that surgery had been recommended for his back, knee and carpal tunnel syndrome, the record does not support such contentions. Instead, the record reveals that Boyd was treated conservatively for all of his impairments. Regarding Boyd's mental impairments, the evidence shows that he has a high school education in regular courses, passed a written test to receive his driver's license and worked for several years in a semi-skilled job.

For these reasons, I find that substantial evidence supports the ALJ's finding that Boyd's allegations are not totally credible.

Boyd next argues that the ALJ erred by failing to find that he met the criteria for mental retardation set forth at 20 C.F.R. § 12.05(C). (Plaintiff's Brief at 11-18.) Again, I disagree. In order to qualify as disabled under § 12.05(C), a claimant's condition must meet two requirements: (1) a valid IQ score of 60 through 70 and (2) a physical condition or other mental impairment imposing additional and significant work-related limitation of function. Additionally, the mental deficits must have manifested during the claimant's developmental stage, i.e., prior to age 22. *See* 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 12.05. The regulations do not define the term "significant." However, this court previously has held that it must give the word its commonly accepted meanings, among which are, "having a meaning" and "deserving to be considered." *Townsend v. Heckler*, 581 F. Supp. 157, 159 (W.D. Va. 1983). In *Townsend*, the court also noted that the antonym of "significant" is "meaningless." *See Townsend*, 581 F. Supp. at 159. The regulations do provide that "where more than one IQ is customarily derived from the test administered, e.g., where verbal, performance, and full scale IQs are provided in the Wechsler series, we use the lowest of these in conjunction with 12.05." 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 12.00(D). *See Flowers v. U.S. Dep't of Health & Human Servs.*, 904 F.2d 211 (4th Cir. 1990).

The medical evidence fails to document that Boyd meets the criteria of § 12.05(C) for mental retardation. First, I note that the record contains evidence that Boyd's IQ was in the 60 through 70 range, meeting the first prong of § 12.05(C). In

particular, testing performed by psychologist Lanthorn revealed that Boyd had a verbal IQ score of 69, a performance IQ score of 68 and a full-scale IQ score of 66. (R. at 162.) Even assuming the validity of these IQ scores, it is questionable whether such mental impairment manifested prior to age 22. For instance, the evidence reveals that Boyd completed high school in regular classes, repeating only the sixth grade. (R. at 160, 219.) Moreover, Boyd testified that he passed a written test to obtain his driver's license, and he has past work experience in a semi-skilled job. (R. at 249, 258-59.) Further, state agency psychologist Milan concluded that Boyd suffered from only a nonsevere anxiety-related disorder. (R. at 165-79.) Milan found that Boyd was not restricted in his activities of daily living, experienced no difficulties in maintaining social functioning, had no difficulties in maintaining concentration, persistence or pace and never experienced episodes of decompensation. (R. at 175.) Milan's findings were affirmed by state agency psychologist Leizer. (R. at 165.)

I note that Boyd does not explicitly challenge the ALJ's decision to grant the opinion of psychologist Lanthorn little weight. However, his next argument that the ALJ erred by failing to grant Dr. Sutherland's opinion controlling weight assumes the validity of Lanthorn's assessment. Thus, Boyd also impliedly argues that the ALJ erred by granting little weight to Lanthorn's assessment. I disagree. Lanthorn concluded that Boyd suffered from a major depressive disorder, single episode, severe, a pain disorder, a generalized anxiety disorder, mild mental retardation and a GAF score of 40 to 45. (R. at 163-64.) As the ALJ noted in his decision, there are only a few vague references to depression and anxiety contained in the record prior to Lanthorn's evaluation in September 2003. Moreover, although Boyd testified that

Dr. Sutherland referred him to Lanthorn, the record suggests that it was Boyd's attorney who sent Boyd for the evaluation. The GAF score assigned by Lanthorn indicates severe symptoms. However, there is no evidence that Boyd ever sought prior mental health counseling or treatment. Furthermore, although Lanthorn found that Boyd had a poor or no ability in the majority of adjustment areas, Boyd's activities of daily living simply do not support such a contention. Finally, although Lanthorn completed a form stating that Boyd's mental impairment manifested prior to age 22, (R. at 210), he gives no explanation for such a finding and, as discussed above, the record simply does not support such a finding and Lanthorn's assessment is entitled to little weight.

For these reasons, I find that Boyd is unable to meet the first prong of § 12.05(C). That being the case, it is unnecessary to analyze whether he meets the second prong. Thus, I find that substantial evidence supports the ALJ's finding that Boyd does not meet the criteria for mental retardation under § 12.05(C).

Boyd next argues that the ALJ erred by failing to grant controlling weight to the opinion of Dr. Sutherland, his treating physician. (Plaintiff's Brief at 18-23.) The ALJ must consider objective medical facts and the opinions and diagnoses of both treating and examining medical professionals, which constitute a major part of the proof of disability cases. *See McLain*, 715 F.2d at 869. The ALJ must generally give more weight to the opinion of a treating physician because that physician is often most able to provide "a detailed, longitudinal picture" of a claimant's alleged disability. 20 C.F.R. § 404.1527(d)(2) (2004). However, "circuit precedent does not require that

a treating physician's testimony 'be given controlling weight.'" *Craig*, 76 F.3d at 590 (quoting *Hunter v. Sullivan*, 993 F.2d 31, 35 (4th Cir. 1992)). In fact, "if a physician's opinion is not supported by the clinical evidence or if it is inconsistent with other substantial evidence, it should be accorded significantly less weight." *Craig*, 76 F.3d at 590. For the following reasons, I find that Boyd's argument lacks merit.

As the ALJ noted in his decision, despite Dr. Sutherland's conclusion that Boyd could not sustain an eight-hour workday, he failed to refer him to a neurologist or an orthopedist for evaluation and/or treatment of his physical impairments. (R. at 29.) Although Boyd contends that he received no such referral because he lacked insurance and could not afford such treatment, there is no evidence contained in the record to support such an allegation. In fact, as the ALJ noted, Boyd testified that he drew a miner's pension until soon before the hearing, his wife received disability benefits and he was able to secure funds from a friend to obtain the mental evaluation by Lanthorn. Furthermore, despite the extreme limitations Dr. Sutherland placed on Boyd, he never ordered that an MRI of his lumbar spine be performed. Moreover, the ALJ correctly noted that despite Dr. Sutherland's very restrictive assessment of Boyd's mental status, he failed to refer him for any psychological counseling or treatment. Aside from this evidence as propounded by the ALJ, I further note that Dr. Sutherland's findings are not supported by his own treatment notes. For instance, while Dr. Sutherland's treatment notes reveal that Boyd consistently exhibited a decreased range of motion of the lumbar spine and positive straight leg raising bilaterally, he placed no restrictions on his activities. Moreover, as previously discussed, there is no evidence that Dr. Sutherland ever referred Boyd to a specialist

for his physical impairments. Instead, he treated him conservatively with medications, heat therapy and Dynawave therapy. Thus, Dr. Sutherland's assessment indicating that Boyd could perform less than a full range of light work, stand and/or walk for a total of one hour each, but for only 10 minutes or less than 100 feet each without interruption, and sit for a total of two hours, but for only 30 minutes without interruption, are inconsistent with his own treatment notes. Moreover, it is clear that Dr. Sutherland's assessment is inconsistent with the record evidence as a whole. For instance, in June 2003, Dr. Iosif found no objective evidence to support Boyd's complaints of shortness of breath. (R. at 139.) In particular, spirometries were obtained revealing normal flows and volumes. (R. at 139.) Boyd also had a normal range of motion of the lumbar spine at that time. (R. at 139.) In July 2003, Dr. Surrusco concluded that Boyd could perform medium work. (R. at 180-87.) Dr. Surrusco's findings were affirmed by Dr. Hartman. (R. at 187.) Finally, Boyd's activities of daily living, as discussed above, do not support Dr. Sutherland's assessment.

For these reasons, I find that substantial evidence supports the ALJ's decision to grant little weight to Dr. Sutherland's assessment. For the same reasons, I find that substantial evidence supports the ALJ's decision to accept the findings of the state agency physician.

Finally, Boyd argues that the ALJ erred by posing an incomplete hypothetical to the vocational expert. (Plaintiff's Brief at 24-25.) I agree. "In order for a vocational expert's opinion to be relevant or helpful, it must be based upon a consideration of all

... evidence in the record, ... and it must be in response to proper hypothetical questions which fairly set out all claimant's impairments." *See Walker v. Bowen*, 889 F.2d 47, 50 (4th Cir. 1989) (citations omitted). The Commissioner may not rely upon the answer to a hypothetical question if the hypothesis fails to fit the facts. *See Swaim v. Califano*, 599 F.2d 1309 (4th Cir. 1979).

I find that the hypothetical posed to the vocational expert did not fairly set out all of Boyd's impairments. The vocational expert found that a significant number of jobs existed in the national economy that an individual of Boyd's age, education and past work experience, who could perform light work, who could occasionally climb, balance, stoop, kneel, crouch and crawl, who should avoid concentrated exposure to extreme cold, heat, wetness, humidity, vibration and hazards and who should avoid all exposure to fumes, odors, gases and poor ventilation could perform. (R. at 259-60.) Boyd contends that this hypothetical is incomplete because it does not account for his mental impairments. I agree. While substantial evidence supports the ALJ's finding that Boyd does not meet the criteria for § 12.05(C), the ALJ nonetheless concluded that Boyd suffered from borderline intellectual functioning, an impairment he classified as severe. (R. at 25, 31.) The ALJ further found that this impairment limited Boyd to simple, unskilled work. (R. at 29.) However, the hypothetical under which the vocational expert found that Boyd could perform a significant number of jobs in the national economy did not contain any such limitation. Thus, I find that it is incomplete and does not constitute substantial evidence to support the ALJ's finding that other jobs existed which Boyd could perform.

IV. Conclusion

For the foregoing reasons, both Boyd's and the Commissioner's motions for summary judgment will be denied, the Commissioner's decision to deny benefits is vacated, and the case is remanded to the ALJ to secure vocational expert testimony regarding the impact of Boyd's borderline intellectual functioning on his work-related abilities.

An appropriate order will be entered.

DATED: This 9th day of March, 2005.

/s/ Pamela Meade Sargent
UNITED STATES MAGISTRATE JUDGE